Child Survival
CONNECTIONS
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Successes, Innovations, and Promising Practices from Projects Around the World

Photo by Olga Wollinka

Volunteers make their way singing and dancing to a Care Group meeting. Everyone in the community recognizes the Vurhonga volunteers by their matching skirts and scarves.

The Use of Care Groups in Community Monitoring and Health Information Systems

Abstract

Care Groups are a community-based strategy for improving the health-related knowledge base of families. Successfully implemented by World Relief in both rural and peri-urban settings in Mozambique, this model focuses on building teams of volunteer mothers who represent and serve blocks of ten households in their villages. This article provides an overview of experience in Mozambique and discusses the key components of the approach—from establishing the block system and the structure of Care Group meetings, to recruiting, training, and testing volunteers. It outlines the administrative structure of the Care Groups in Mozambique, reviews quality assurance measures that have been implemented to monitor their success, and discusses the relative advantages of Care Groups in comparision to the management of individual volunteers. A replication of the Care Group model in Cambodia is also briefly discussed.

Introduction

In World Relief's (WR) child survival project in Mozambique (project cycles XI and XV), program monitoring proved challenging because so few volunteers could read or write.

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Participatory Evaluation Involving Project Stakeholders:

A promising practice for increasing active collaboration and use of information by project teams

Does your project team wince at the prospect of an evaluation? Are team members nervous about being evaluated? Or does the team view the evaluation process as an opportunity for self-assessment of activities, interventions, and strategies? Is an evaluation perceived as a chance for staff to share their own experiences, observations, concerns, and suggestions with others from all different levels of the project? Do project implementers foresee an evaluation as an opportunity to learn new practical skills in an experiential mode? Is the information gathered from the evaluation process going to be directly applied to adjusting the project activities or strategies?

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Photo by Sylvie Diara

Participatory evaluation involves everyone who has a stake in the project—from implementers and local partners to beneficiaries and their families.

Community-Based Monitoring: What is it for?

The primary objective of collecting information is to aid community members in their decision-making. On a secondary level, project managers use information to make good decisions and to report progress to other key stakeholders, including donors. In order for this to happen, information needs to be **a)** timely, **b)** practical and applicable to the person using it (preferably collected by people involved in the project), and **c)** specific — it is good to know that 50 percent of the children are immunized, but at the village level it is better to know which 50 percent. At the caregiver level even more specific information is needed. Which child has been immunized and which has not? More general information is sufficient for overall project planning. At the village level, however, collected information should be very specific and those collecting the information should use it right away.

GLOSSARY

Volunteer: A woman chosen by her block of 10 families to give leadership to the block.

Care Group: A group of 10 volunteer mothers. Each volunteer represents and serves a block of 10 households.

Animator: A project salaried worker who trains and supervises Care Groups.

Supervisor: A project salaried worker who supervises the animator.

WR had to construct a monitoring system that would allow for solid results reporting without large amounts of paperwork for the volunteers. The program field staff, led by Dr. Pieter Ernst, developed a simple methodology for collecting information at two levels: 1) oral reporting on specific households at the Care Group meetings; 2) quarterly mini-surveys to track project objectives. Although this article will discuss information collection at both levels, it will focus on the household level, where volunteers are organized into Care Groups.

By creating a timely, practical, and specific system to consistently track the health of the beneficiaries in their project area and reporting those results directly back to the community, World Relief has been able to meet one of the original goals of the project — to "empower communities to make decisions that protect the growing minds and bodies of their children." They have also been able to analyze information over time in order to make good decisions for project management and donor reporting. The Care Group method of community monitoring and information management shows promising potential for replication of grassroots involvement in child survival.

Setting

The Vurhonga (Dawn) Child Survival Project is located in Gaza Province, Mozambique. The first cycle of the project began in 1995 in the Guijá and Maabalane Districts and continued through 1999, when a final evaluation was completed. The second cycle began in Chokwe in 1999 and will continue until 2003. Vurhonga serves 38 rural villages and one peri-urban town in the Guijá and Maabalane districts. These villages consist of 15,200 households. The beneficiary population is 34,000 women and children, and the total area population is 91,200. Women are responsible for most food production, wood and water gathering, and childcare. Of the mothers surveyed for the baseline, only 27 percent were literate. Shangaan is both the mother tongue and the ethnic identity of the people.

The project area has never been a prosperous one. War and climatic conditions (such as

drought, and then the floods that swept through the district in the spring of 2000) have kept the people at a subsistence level. More than half of the men in the area work in South Africa. During the first four years of the project, displaced people trickled into the project area in a slow but steady stream.

The Shangaan place great value on children who will take care of them in old age. According to the project's mid-term evaluation, a woman must continue to bear children as long as the cows given for her dowry are still calving. This belief contributes to very low rates of contraceptive use.

The World Relief Approach

Block system

The Vurhonga project built on two previous WR initiatives (wells and community banks) in Gaza Province. Project planners knew the area well and recruited the project's volunteers based on an existing block structure. A block consists of ten families, and one woman volunteer represents each block. The block structure was originally created by the Organizaçoa da Mulher Moçambicana (Women's Organization of Mozambique), known as OMM, to organize women for community health action.

An extensive project census in combination with the pre-existing block structure ensured that no houses were left out of the project. Every woman 12 to 49 years old and every child under the age of five in the project's catchment area could be reached with project health messages and activities. If families returned to their homesteads after the census had been completed, the additional household was reported in the Care Group, and the women and children were added to the project register.

LESSON LEARNED

A census is necessary in order to ensure that all residents are included in project activities

Volunteers: The base of the pyramid

Volunteers were trained by female World Relief salaried workers known as animators in both child survival interventions and health messages. As volunteers are trained, they visit homes and talk to mothers on a

Photo by Olga Wollinka

Each year the volunteers received a reward for their participation in the program. Here a supervisor (right) presents a volunteer with a button featuring the project logo.

one-to-one basis, sharing what they have learned and helping to answer the mother's questions about the subject the volunteer is presenting. They also discuss any births, deaths, pregnancies, or illnesses within that household.

Each block already had a woman appointed as a volunteer OMM representative. Originally the project's Detailed Implementation Plan (DIP) called for the OMM leaders to be the volunteer mothers on their block. However, this approach caused some difficulties. The final evaluation states that the project leaders made revisions to the volunteer selection criteria because some of the OMM leaders were older women who were "accustomed to giving orders rather than encouraging communication for behavior change."

"At first we thought the women were just being busy-bodies. But now we see that they've really accomplished a lot. These women now receive honor in the eyes of the male village leaders."

Under the revised plan, project volunteers would be elected by the community. This election would allow some younger women to be chosen because of their ability to read and write which, despite their youth, gave them prestige in the community. Overall, both older and younger women were elected to serve as volunteers. Six hundred seventy-one had been elected by the mid-term evaluation and 1,500 by the final evaluation.

The volunteers were organized into Care Groups, with each group consisting of eight to 10 volunteers. Each Care Group then elected a leader — a volunteer who held status in her immediate community.

Group meetings

The Care Groups meet for at least two hours twice a month for training, reporting progress of home visits, evaluating, and planning. Volunteers verbally report on the status of the women and children in their block. This method (in contrast to a written report filled out by each volunteer) allows for a mix of literate and illiterate volunteers. One volunteer in the group must be literate—she is the designated secretary. The secretary is responsible for keeping the register on project forms (pregnancies, births, deaths, and vaccine-preventable diseases) as each volunteer verbally reports on the health status of the ten homes in her block. The animator then reports on the status of the families in her area at a weekly staff meeting in the project headquarters office in Chokwe.

LESSON LEARNED

Reporting verbally through group meetings allows participation regardless of literacy levels.

Care Group meetings also provide a forum for problem-solving discussions. When problems are reported, possible solutions are discussed within the group so that immediate action can be taken. The women help each other with the application of the knowledge they have just learned. This can include relating experiences that they have dealt with themselves, such as "I had a mother who just would not breastfeed and this is what I did about it."

Group meetings consist of a mixture of activities and are social as well as educational. The ladies enjoy communicating in traditional ways (dancing and singing together) in addition to discussing health and recording statistics. As well as gaining new ideas, volunteers are encouraged to keep persevering in their work.

Whether this type of group-bonding would work if male health workers were part of the group has not yet been ascertained. However, a new child survival project planned in Malawi will incorporate male health workers as well as females. That project will explore the dynamics of using mixed-sex Care Groups.

Training

Using training materials that had been written in Shangaan and prepared to reflect the culture, WR animators introduced project

Photo by Olga Wollinka

World Relief's three supervisors (left) and health educator (right) work closely with volunteers in the Guijá and Maabalane districts. The supervisors are able to oversee 19 animators and 1,520 volunteers because the Care Groups distribute supervisory responsibilities.

interventions one at a time. The theme for the meetings changed, depending on what health interventions the project was phasing in or what health situations the project was responding to. For example, during malaria season discussions would turn to recognition and rapid treatment of malaria and care and use of bednets.

Training the volunteers in the context of the bimonthly group meetings allowed animators to use group-learning activities (such a songs, dance, and drama) that would be impossible with one-on-one training.

Some of the volunteers have continued using the nontraditional learning techniques they learned in training for their home visits. They have paired up, with one acting as a health educator and the other as a storyteller, weaving stories to emphasize each health message.

Learning Reinforcement

The Vurhonga project established systems to ensure that both the individual Care Group members and each group as a whole had the knowledge and skills necessary to work with the families in their areas. This system incorporated strategies for testing individual knowledge and performance as well as group knowledge. Group reviews were also included.

As the interventions were phased in, volunteers were tested on their knowledge. This phase-in strategy seems to have worked quite well, since the Care Groups were able to demonstrate their comprehension of one intervention before moving on to the next.

LESSON LEARNED

Phasing interventions in slowly during training facilitated volunteers' ability to assimilate the information and use it immediately in their work.

Volunteers were tested on their knowledge of specific interventions. The examinations were oral, and conducted in the local language of Shangaan. The quizzes were used to reinforce what they had learned, as well as to assess the capacity of Care Groups to continue the intervention without the constant support of the animator. Although there were never any comprehensive quizzes, animators conducted reviews of all the interventions during the last two years of the project.

According to the final evaluation, examinations were specific to each intervention (diarrhea control, malaria control, growth monitoring/nutrition, immunizations, maternal health and family planning, and HIV/AIDS).

For example, for the nutrition intervention volunteers were required to:

- Know the individual nutritional status of children on her block
- Correctly interpret a Road to Health card
- Demonstrate the ability to do nutritional counseling without becoming judgmental
- Know causes of malnutrition
- Recognize the signs and symptoms of malnutrition and be able to refer to the local clinic
- Be able to prepare the enriched porridge used in Hearth groups
- Know the functions of the four food color groups and give examples of each.

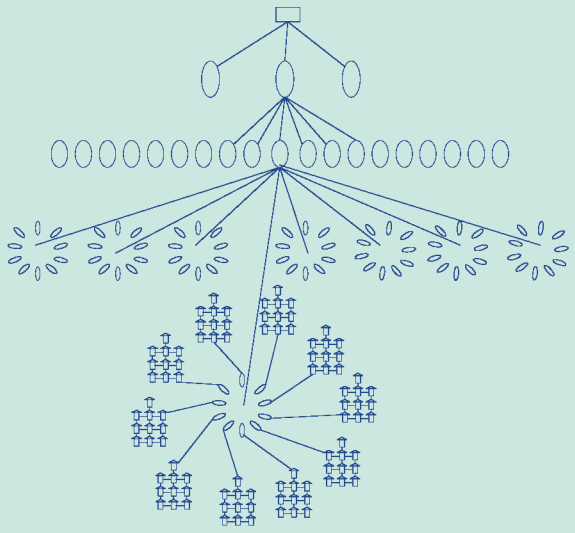
Volunteers are quizzed orally during the regular bimonthly Care Group meeting. In order for the group to pass, the average score of the entire group needs to be at least 60 percent. One hundred percent accuracy for all the women is not realistic, however, critical mass is suggested if sixty percent of the volunteers are able to answer the questions correctly. The advantage of this system is that if a volunteer does not know the answer, she knows who else in her group does know. She can then turn to that person for advice when she needs it. Volunteers who are not present for the exam receive a grade of "0," which drastically brings the average score of the group down. Participation in the examinations has to be high for the group to pass.

If a group as a whole does not pass the exam, the same exam is repeated a month later, after additional training from the animator. The stronger members of the group are able to work with the weaker ones to strengthen their knowledge and skills in the intervention. Through team effort the entire group passes the test. When a group does pass, its members celebrate with songs and dance.

LESSON LEARNED

Multiple strategies for individual and group learning reinforcement ensure that volunteers are well prepared to serve the families on their blocks.

In addition to group-knowledge testing, each volunteer's performance is assessed quarterly through house visits held jointly by the volunteer and her animator. The animator uses a checklist to record performance and uses it as a basis to provide feedback to the volunteer. During the first year of the project, checklists concentrated on interventions and messages. As the project progressed, animators focused more on counseling skills and application of knowledge to the situation at hand.



The Project Director
and **coordinator** oversee

3 Field Supervisors
responsible for

19 Animator/trainers, each
working with 8 Care Groups

For a total of

152 Care Groups
(1520 Volunteer mothers)

Each volunteer works with 10
households, for a total of

15200 Households

Rewards

The Care Group members received one tangible reward per year for their involvement. The first year it was scarves, the next year skirts, then pins, then T-shirts. The pins seemed to be the least favored. Clothes were much more valued, because they can be worn all the time. The clothing also helps with volunteer recognition. Everyone in the village knows who the Vurhonga volunteers are, in part because of their matching scarves and skirts.

LESSON LEARNED

Rewards can function as motivators as well as for recognition and group identification.

Administrative structure

The administrative supervision of the 15,200 households in the catchment area is as follows:

A Project Director and Coordinator oversee the work of three field supervisors.

Three supervisors are responsible for 19 project animators.

19 animators work with approximately eight Care Groups (of 10 volunteers each).

1520 volunteer mothers each work with the 10 households in her block.

Results Sharing

Information from the Care Groups trickles up to project management. Every other week the project animators verbally report on each of the under-five deaths in their area. They, along with the project director and health educator, discuss the probable cause of death and whether or not it could have been prevented, as well as other topics related to the information.

Care Group leaders send a monthly report to the Village Health Committee and to the health post. This information is included in the health post's monthly report to the district, thus establishing a local link between the Care Groups and the Ministry of Health. Project information is posted and discussed at the Ministry of Health and at the health centers.

Dr. Pieter Ernst, Vurhonga Project Director, is also one of the Ministry of Health (MoH) physicians. He works in the district MoH clinic one day a week, helping to strengthen the ties between the project and the Ministry of Health. This strengthening has greatly increased the cooperation between the project and the MoH. As Olga Wollinka, WR Child Survival Program Specialist, comments, "because of Pieter's involvement in the Ministry of Health, the MoH sees these figures as their figures."

LESSON LEARNED

Information sharing and relationship building with the community and the MoH are essential to building local ownership of the project.

"Our husbands want us to continue. They are glad that our own children are healthier. They even want us to go to [more training]."

Project staff periodically held meetings with the village leaders to share the information the Care Groups had gathered about the health of the women and children in the village. Because the project was working in a very oral society, they found it most useful to hold meetings and verbally report their findings, rather than have charts and graphs posted in public places.

During the final evaluation, some village leaders admitted that "at first we thought the women were just being busybodies. But now we see that they've really accomplished a lot. These women now receive honor in the eyes of the male village leaders."

Photo by Olga Wollinka

The Vurhonga Project's field supervisors and animators take a short brak to pose for a picture. Teamwork is essential to making this project a success.

The husbands of the volunteers seem to be quite supportive of the program as well. One group of volunteers stated that "Our husbands want us to continue. They are glad that our own children are healthier. At first our husbands said, 'why are you going around visiting others? You should be here preparing my meal and working on our home.' But now they remind us to attend the Care Group meetings. They even want us to go to [more training]."

Quality assurance

Volunteer home visits are the foundation of the health information system and the family-level health education program. In order to ensure that the data being collected in the groups is reliable for program planning and donor reporting, the program uses a modified lot-quality assurance technique that Dr. Ernst developed. Using this system, program managers collect enough information to yield statistically significant results to verify the validity of the Care Group reports and to make management decisions.

In this modified lot quality assessment, each animator is a "lot," and there is a re-emphasis on the project goals and objectives. Every quarter one Care Group from each of the animators is chosen at random. That group is then assigned to another animator-trainer. Each and every one of the families within that Care Group is surveyed. Each mother in the project area is chosen only once, due to the fact that Care Groups are not surveyed more than once.

LESSON LEARNED

Quarterly surveys can be used to verify the data collected by the volunteers.

For ease of comparison, animators use a sampling of the baseline KPC survey questions (approximately 15 questions each). Over time these rapid surveys cover most of the project indicators. The data set from this survey is then analyzed and can be used to monitor progress on project objectives. The process takes about three days for surveying, analysis, and discussion.

All the animators analyze the data together, then report back to their groups. If the results show that a group is not doing very well, or if animators notice in a group meeting that some volunteers are doing well and others are not, women are paired up to support each other. The volunteers are graded as "A," "B," or "C." A volunteer doing very well (an "A") will go visiting with a volunteer who is not doing so well (a "C"). This system makes it possible for an animator to manage 60 to 80 volunteers in all of her Care Groups—some supervision can be delegated to the

volunteers themselves, and the trainer is not required to do all of the coaching herself.

Although there was originally some concern that the KPC mini-surveys might be more representative of one animator's work than the project as a whole, the quarterly reports (including results from all the animators tested) correspond closely to the results of the full mid-term and final evaluation KPCs. The indicators have also echoed the work of the volunteers at the community level.

Advantages of Care Groups

The Mozambican culture places a high value on community. Personal relationships and group cohesiveness are both very important. The Care Group structure works well with the Mozambican value of community. Rather than each volunteer working individually for a goal, they work together in small groups within the community. This approach allows them to support each other, and to learn from each others' successes and mistakes. The Care Group acts as a source of encouragement and social support for the volunteers.

Music is also used extensively by the volunteers as a way to express health messages and to unify them as a group. Groups of volunteers are continually writing new songs, to the point where the project Health Educator cannot keep track of how many there are. An example of one of the songs sung for the evaluators is the following:

"Mother, where are you mother?
Give me the milk of your breast so
I can see the light of dawn and live in beauty.
Thank you mother for the milk of your breast.
May you live many years and be strong, be strong, be strong."

Following verses replace the phrase "milk of your breast" with "enriched porridge," and then "fruits and vegetables."

This approach fits well within the cultural context of the project site, where much information is traditionally communicated through song, dance, and drama. These songs make a large contribution to the sustainability of the project — they are a powerful tool for helping volunteers, literate or not, remember the intervention information they have learned.

LESSON LEARNED

Group meetings can function well as avenues for problem solving, peer counseling and social and educational activities as well as for training and testing.

Having a manageable caseload and the support of the Care Groups helped to create a very high level of volunteer morale. Volunteers were able to acquaint themselves fully with all of their assigned families without having to rely on a written roster. As the final evaluation states, "In neither the mid-term nor final evaluation did the volunteers sound an oft-familiar refrain of 'working without pay.' The Care Group re-framed the service of the volunteers from 'doing World Relief's job without pay' to 'helping our community together.'"

' The Care Group re-framed the service of the volunteers from 'doing World Relief's job without pay' to 'helping our community together.'"

Families in the project area seemed to appreciate these volunteer home visits, and expressed high demand for them to return. This is not to say that the volunteers encountered no resistance to behavior change. Success is due in part to the persistence of the volunteers even when they did encounter resistance. As the final evaluation states, "mothers repeatedly referred to the fact that volunteers continued to visit them at their homes, even when initially they were not receptive to the new messages."

Volunteer turnover has been very low. Of the 1,613 volunteers trained in the project (as of the final evaluation in August 1999) only 86 (5.3%) chose to drop out of the program. Forty-five volunteers (2.7%) quit because they moved to another village, and 36 (2.2%) died.

As consultant Donna Sillan pointed out, "the

Photo by Olga Wollinka

This volunteer brought her child to the Care Group meeting, where she will learn more strategies for keeping her baby and the children on her block more healthy.

beauty in individual home visits is that health messages can be tailored to each family's current situation." This personalization can make the health messages seem much more practical and useful. "For example," Sillan continues, "if a child is suffering from diarrhea, yet the message of the month is immunization which is all the volunteer is talking about, the mother may feel discouraged and unable to absorb information which isn't her top priority. The volunteer needs to prioritize health issues within the household and speak to those first. The 'flavor of the month' can be discussed, but maybe not emphasized."

Replication: Cambodia

The Care Group method of health promotion and information gathering is also being used in the World Relief project in Cambodia. The "Light for Life" child survival project serves both peri-urban and rural areas in five communes of Ponhea Kriek District in Kompong Cham Province. It is located on the Ho Chi Minh trail, close to the border of Vietnam. While many of the elements are the same for both projects, there are some significant differences.

In contrast to the Care Group program in Mozambique, the WR Cambodia program holds Care Group meetings once a month, accommodating Cambodian women's work schedules. Typically women work in the rice paddies 10 hours a day. For these women, time spent in a meeting is time not spent making money. According to the Detailed Implementation Plan, Care Group schedules may have to vary according to the agricultural calendar, especially during planting and harvest seasons. This was also true in Mozambique.

The volunteers in Cambodia each work with 15 households (as opposed to 10 in Mozambique). Cambodian houses tend to cluster in groups of 15 to a clearing, providing a natural group of families with which each volunteer can work.

The proposal for the Cambodia grant did not include Care Groups. This idea was suggested during the DIP preparation. The funded budget called for a much smaller staff than what would be required to support a large number of volunteers. By having each volunteer care for 15 houses instead of 10, fewer volunteers are required to cover the entire population. In Cambodia the total number of volunteers is 900, in contrast to Mozambique's 1,500. This number is much easier to supervise with a smaller staff of 14 without causing burnout. In Cambodia all of the animators have motorbikes and the project area is much smaller overall, with the villages located quite close to each other.

Because the Care Groups meet only once every month, it is difficult to do all the training at the sessions themselves. Cambodian volunteers receive two full days of initial training in each intervention as it is phased in, in contrast to the training in Mozambique, which took place solely in the context of the Care Group itself. Cambodian training is conducted by the WR staff with the Ministry of Health staff. Follow-up training is done in the Care Group. Although the volunteers receive a travel allowance for the training done by the Ministry of Health, volunteers are never paid for their attendance at the Care Groups. It remains to be seen whether the schedule of training meetings is too difficult for the volunteers to manage.

LESSON LEARNED

Responsibilities can be successfully transferred from paid staff to community members when group leadership and decision-making power has been systematically built.

The spirit of community is not as great in Cambodia as it is in Mozambique. This outlook has made it more challenging for WR to recruit volunteers (called women health educators in this project). However, volunteerism increased substantially when the women saw the nature of the training.

It is still too soon to tell whether the Care Group structure will be as successful in Cambodia as it has been in Mozambique, but the early signs are very promising. In time, this project will be able to provide a host of information on the process of replicating Care Group structures in locations that are quite different from the villages of southern Africa.

Conclusions

Results and Sustainability

According to the final evaluation, the Vurhonga project in Mozambique surpassed all of its stated objectives. Much of the success of the project has been attributed to the combination of increased awareness and improved access to available, appropriate treatment, whether it be ORS, chloroquine, or child-spacing commodities. The improved knowledge base of families at the community level was a major factor in increasing child nutritional status.

The key to Care Group sustainability is unity and continued group cohesiveness. During the final evaluation all of the groups expressed "high levels of confidence" that the

Photo by Olga Wollinka

A project volunteer proudly wears her Vurhonga project button, scarf, and skirt. Scarves and skirts, and T-shirts were the most popular volunteer rewards.

Photo by Olga Wollinka

One of the project volunteers has a good laugh during a Care Group meeting. In addition to being an information-sharing forum, meetings are social, fun times where women of all ages laugh and sing together.

groups would be sustained even after the project is no longer receiving funding and the paid animator-trainer is gone.

Just as the interventions were slowly phased in, responsibilities were slowly shifted from the project-paid animators to the Care Group leaders. One Care Group is currently recruiting more volunteers, and the current group members are doing the training themselves. Another Care Group has planned and implemented its own Hearth session, after seeing the project use that methodology. As final evaluators stated, "The group dynamics of this structure have resulted in a special bonding between volunteers and their community that has taken a life of its own."

The community support structure developed by WR, touching every household and linking communities, achieved its purpose of increasing the potential for sustained behavior change. The large number of volunteers, the peer support available in the Care Groups, and the project inputs that strengthened the structure's effectiveness together transformed a health education project into a community movement for health that the final evaluators called a "vibrant and sustainable community support structure."

As the final evaluation states, a group of a dozen elderly women in one of the project villages expressed their confidence in sustained behavior change in the following way: "We have taken off old, dirty clothes and put on new, clean ones. Nobody will ever take off their clean clothes and put on dirty ones again. . . [Our children] are not dying. We will not go back to the old ways."

For more information

If you have questions about these projects or the Care Group methodology, please contact:

- Melanie Morrow, World Relief Child Survival Program Specialist, mmorrow@wr.org
- Dr. Pieter Ernst, Vurhonga Project Director (Mozambique), pernst@wr.org
- Kay Hansen, Cambodia Project Director, kay@camnet.com.kh

Note to the Reader

It appears that the Care Group structure established in Mozambique has withstood the ravages of the floods in the area. Although the population was evacuated for a time, families have now returned and Care Group meetings are continuing as normal. As families returned to their land, project animators were involved with seed and tool distribution and the volunteers have helped to provide a structure for the distribution of relief supplies.

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Monitoring and Evaluation Excerpt from the World Relief/Cambodia Grant (distributed by Olga Wollinka at the CS Project Manager's Workshop)

January and February monthly reports from WR CS XIV Cambodia to WR headquarters

Email and telephone interviews with Olga Wollinka, World Relief Child Survival Program Specialist

Written by Rikki Welch

Participatory Evaluation...

continued from page 1

A Different Kind of Evaluation

If your staff doesn't see an evaluation as an opportunity for sharing experiences and improving the project, perhaps you ought to try a different kind of evaluation. A participatory evaluation approach can foster the collaboration of project staff (including local partners) and other stakeholders in taking stock of the project's strategies, implementation procedures, and progress toward achieving the results it has proposed. In addition to seeing whether the milestones are being met, the participatory approach emphasizes looking at the processes from the perspective of all the different actors or stakeholders. Persons directly involved in the project activities, from the level of the trainers of community volunteer health workers to the Ministry of Health directors, are especially encouraged to share their perspectives. The community health volunteers, the local beneficiaries, and even nonparticipants are actively involved in presenting their observations about and experiences with project activities.

If your staff doesn't see an evaluation as an opportunity for sharing experiences and improving the project, perhaps you ought to try a different kind of evaluation.

A structured participatory evaluation methodology can be an excellent practical training exercise in applied monitoring and evaluation (M&E). The participatory evaluation process provides an excellent practical setting for training a gamut of partner and project staff in developing a visual map of the project, identifying key issues to be investigated, designing evaluation questions for each component, and collecting and analyzing information. Information that staff collect includes qualitative data to produce lessons learned and an action plan to directly use the information for improving project activities. Elements of the participatory evaluation approach can be incorporated into ongoing monitoring of project components for continual learning and adjustment.

Photo by Sylvie Diara

Workshop participants visit a local health hut to practice their interviewing skills. Skillful open-ended questioning is key to the information-gathering process.

Consider the experience of Laura Hoemeke, a consultant who was involved in a participatory midterm evaluation of a child survival project in Burkina Faso in 1995:

It was fascinating to observe the impact of the evaluation on the project staff and partners. When we first presented the evaluation to the staff, they were confused. Most of them had participated in evaluations that had been more like 'inspections' and 'controls' than learning experiences. When we asked them what they wanted to learn from the evaluation, they didn't know what the 'right' answer was. . . Weren't the evaluators supposed to know what they wanted?

As the days went on, the staff became fully engaged in the process of formulating questions, figuring out how to get the information they wanted, gathering information, and analyzing the data. As we worked together on analyzing the data, the lessons learned and recommendations for improving the project became obvious to all of us. We saw together what it would take to make the project work better.

At the end of the evaluation process, we conducted 'exit interviews' with the staff. Most of them said that this had been one of

the best work experiences they had ever had. They also felt as though the evaluation report wasn't even necessary, because they had learned all they needed to by participating in every step of the evaluation.

Photo by Sylvie Diara

For a participatory evaluation to truly reflect the opinions of the community a project serves, evaluators must spend a significant amount of time in discussion with community members.

Perhaps the one disadvantage of a participatory evaluation approach is the considerable time investment it requires. Renee Charleston, a consultant experienced in participatory evaluation methodology, points out that "the more participatory the approach, the more time is needed." Most everyone who has been involved in this type of evaluation however, agrees that the investment is worth it, because the recommendations developed are relevant. Abdou Mbengue, child survival project field agent for World Vision in Senegal, puts it this way, "We won't be able to forget the lessons learned that we have formulated. Even if the report gets lost we can't forget everything that we have decided on together."

New Emphasis by USAID

As part of reengineering, USAID is promoting participation in all aspects of its development work. A Statement of Principles on Participatory Development was issued in 1993, in which J. Brian Atwood identified access and participation by local people in decision-making processes as a result USAID seeks to support. He identified participation as being fundamental to sustained development. Other USAID publications have also stressed that there needs to be broad participation by local people in defining development priorities and approaches in order to ensure that development programs are relevant to peoples' needs. Participation describes both the end and the means.

To support this goal of more participatory development, The USAID Center for Development Information and Evaluation published "Performance Monitoring and Evaluation TIPS on Conducting a Participatory Evaluation" in 1996. This quick overview of the approach can be downloaded from the Development Experience Clearinghouse Web site at www.dec.org/pdf_docs/pnabs539.pdf

The PVC Guidelines for Child Survival XIII Mid-term Evaluations also clearly identify the desirability of a participatory approach. Section III, "The Action Plan," states:

The importance of encouraging local actors to examine the situation, prioritize needs, and take initiative for creative problem solving to improve their well-being cannot be overstated . . . . the opportunity to have an exchange of ideas with others who have wide involvement with child survival activities in different places potentially makes the MTE a pivotal learning experience.

The guidelines go on to say (in bold letters) that "the resulting Action Plan should be carefully constructed with high participation and consideration of many viewpoints and adopted by the vast majority of stakeholders."

At the end of the evaluation process, we conducted 'exit interviews' with the staff. Most of them said that this had been one of the best work experiences they had ever had.

Child Survival and Participatory Evaluation

Interestingly, despite the renewed emphasis on it, many child survival projects do not fully embrace a participatory evaluation methodology and many continue to submit to being evaluated by classic evaluations largely driven by outside evaluators. Even when a

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participatory approach is adopted, it most often focuses on gaining input from the project beneficiaries by interviewing individuals or focus groups. The actual project implementers may be mobilized to assist with logistics such as arranging for community visits or occasionally to accompany a visiting outside evaluator. However, staff persons with the most project activity contact are still not routinely involved in the design of the evaluation questions and activities or in the data collection and analysis process. Unfortunately they are not empowered to actually use the information to design a better project, either.

It doesn't need to be this way. The objectives of an evaluation, especially a mid-term evaluation, can explicitly include the aim of developing M&E skills among the project team staff, with the goal of developing sustainable organizational skills. These skills include the ability to identify the most useful information for the project or program, and to use that information to improve the capacity to deliver and continuously monitor health education activities and outcomes, as well as quality of services, in a systemic manner. A methodological approach such as this one provides a structure that enables managers to organize very complex programs into manageable components for evaluation. This approach is not limited to health and nutrition and should be useful for any staff in evaluating any project. (Susan L. Hahn, Foreward, First Edition *Participatory Program Evaluation*).

New Evaluation Manual Available

The Child Survival Technical Support Project (CSTS) has supported the updating and dissemination of a practical, 20-step methodology for involving program/project stakeholders in a participatory evaluation process. The process moves from diagramming the elements of the project and developing evaluation questions, to collecting and analyzing the information with emphasis on extracting lessons learned. The analysis is used to immediately develop an action plan for future project direction. CRS published the first edition of the *Manual for Participatory Program Evaluation: Involving Stakeholders in the Evaluation Process* in 1994. It has been used by a number of evaluation coordinators over several years. CSTS has supported the updating, expansion, and publication of this manual in English, French, and Spanish as a resource for child survival and other development projects. It is available on the CSTS web site at www.childsurvival.com/bookmarks/bokshelf.asp. Those without Internet access can send requests for the manual to: csts@macroint.com.

Worth the Time

When CSTS sponsored workshops on the methodology in Bolivia, Haiti, and Senegal, attendees unanimously voiced their appreciation for the participatory approach because it allows them to play a major role in designing and managing the evaluation process. The goal of participation is to develop a highly collaborative team spirit with all project stakeholders and to effectively use the evaluation process as a learning forum, drawing out lessons relevant for constructing an action plan for improving their project strategy, activities, and results.

Photo by Sylvie Diara

Local women demonstrate their knowlede of a variety of Vitamin A-rich foods by filling calabashes with an assortment of vegetables. Visitors and project staff take part in the participatory learning exercise together.

As Robb Davis of Freedom from Hunger explains, when a participatory methodology is used, "Evaluation is no longer a threat, but an opportunity to pause, reflect, learn, and regroup to meet the challenges ahead."

References:

Aubel, Judi. "Reorienting Program Evaluation to promote organizational learning: Participatory stakeholder-driven evaluation," Unpublished article, July 1999.

Aubel, Judi. Participatory Program Evaluation: *A Manual for Involving Program Stakeholders in the Evaluation Process*, 2nd Ed. Available from Child Survival Technical Support, Macro International, 11785 Beltsville Drive, Calverton, MD 20705. www.childsurvival.com/documents/csts.cfm

USAID CDIE Performance Monitoring and Evaluation Bulletin "Conducting a Participatory Evaluation." (No. 1) www.dec.org/pdf_docs/pnabs539.pdf

More information on participatory development and evaluation can be found on the Internet. Some recommended sites include:

- USAID's Participatory Development Web site: www.info.usaid.gov/about/part_devel
- The World Bank Participation Sourcebook www.worldbank.org/wbi/sourcebook/sbhome.htm
- Web Links To Participatory Action Research Sites www.goshen.edu/soan/soan96p.htm

Written by Sandra Bertolli

Child Survival
CONNECTIONS

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Rikki Welch, Editor

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